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August 10, 2004

To: Community Care for the Aged and Disabled (CCAD)
Primary Home Care (PHC) Program Providers

Subject: Long Term Care (LTC)
Information Letter No. 04-23
Revisions to Primary Home Care Program Fiscal and Contract Compliance
Guides, **Effective December 1, 2004**

As a result of the Texas Department of Human Services (DHS) adoption of the new Chapter 47, "Contracting to Provide Primary Home Care" effective June 1, 2004, the attached Form 3858, Primary Home Care Program Contract Compliance Monitoring Guide, and Form 3059, Primary Home Care Program Fiscal Monitoring Guide, and forms instructions have been revised. The forms now include new and revised monitoring standards which are consistent with the new program rules.

Staff will not conduct any monitoring reviews for the period of August 1, 2004 through November 30, 2004. Staff will begin using the revised Form 3858 and Form 3059 beginning December 1, 2004. The revised forms and instructions can be accessed December 1, 2004, at the website below:

<http://www.dhs.state.tx.us/programs/communitycare/forms/index.html>

A computer based training (CBT) for the monitoring forms and new rules will be available for provider agencies to complete upon receipt of this letter. You may access and download the CBT at the following link: <http://www.dhs.state.tx.us/cbt/index.html>. Please insure that your resolution settings are at 800 x 600 pixels to view the CBT on full screen. This CBT will be available on an ongoing basis, however, contract monitoring staff will begin using the revised monitoring forms with review months beginning with October 2004. The review period for monitoring reviews conducted in December 2004 and January 2005 are as follows:

<u>Review Conducted</u>	<u>Fiscal Review Month</u>	<u>Compliance Review Period</u>
December 2004	October	October
January 2005	October	October and November

Staff will resume review of full review periods for all monitoring reviews conducted after January 31, 2005.

Revisions to the forms are summarized below:

Form 3059 – Primary Home Care Program Fiscal Monitoring Guide

General Changes

- Changed the title from Financial Errors Standard to Primary Home Care Program Fiscal Monitoring Guide.
- Revised the Financial Errors Standard Chart.
- Added Texas Administrative Code (TAC) rules for financial errors to the monitoring form.
- Financial error 4 was replaced with financial error 4 and 5.
- Previous financial error 5 is now financial error 6.
- Added financial error 7.
- Revised the form instructions.
- Removed any reference to Day Activity and Health Services (DAHS).

Form 3060 – Primary Home Care Administrative Errors Standard

- Form and instructions will be deleted.

Form 3858 – Primary Home Care Program Contract Compliance Monitoring Guide

General Changes

- Changed the title from Compliance Monitoring Guide for Contract Performance Standards (Primary Home Care Services Agencies) to Primary Home Care Program Contract Compliance Monitoring Guide.
- Removed the notes section from the monitoring form and incorporated monitoring protocols to the monitoring form instructions.
- Replaced any reference to 1929(b) Primary Home Care (Frail Elderly) with Community Attendant (CA) Services.
- Deleted specific form numbers.
- Replaced any reference to provider agency Registered Nurse (RN) with supervisor.
- Replaced any reference to health assessment with evaluation.
- Revised standards to reflect practitioner's statement.
- Revised standards to reflect negotiated referrals. Transfer cases are negotiated with case managers and will be reviewed as negotiated referrals where applicable.

- Added three new standards as follows: Standard 4 – Attendant Orientation, Standard 5 – Service Plan Changes, and Standard 6 – Annual Reauthorization.
- Changed previous Standard 4 from Service Breaks to new Standard 7 – Service Interruptions.
- Deleted Primary Home Care manual references and replaced them with new TAC rule references.
- Revised the form instructions.

Standard 1 – Pre-Initiation Activities

- Changed Standard 1 from Initial Health assessment to Pre-Initiation Activities.
- Deleted the requirement of whether an RN or someone who is not an RN should supervise the attendant.
- Deleted the request for prior approval from DHS Regional Nurse.
- Added the requirement that states provider agencies are only responsible for providing services allowed through the Primary Home Care program.

Standard 2 - Service Initiation

- Replaced the requirement to send notification to case managers for failure to initiate services with the need to document reasons for delay.
- Revised the notification requirements sent to the case managers after services have been initiated.
- Deleted the term special attendant. The method of orientation must be conducted as described in TAC rule.
- Deleted the requirement of Form 3040, Attendant Orientation/Supervisory Visit, and replaced it with the required elements that must be documented.
- Added the requirement for retroactive cases.

Standard 3 – Supervisory Visits

- Changed Standard 3 from Ongoing Services to Supervisory Visits.
- Added the required elements that must be documented when a supervisory visit is conducted, as Form 3040, Attendant Orientation/Supervisory Visit, is no longer a required form.

Standard 4 – Attendant Orientation

- Moved the requirements for attendant orientation from Standard 3 to Standard 4.
- Deleted the term special attendant. The method of orientation must be conducted as described in TAC rule.
- Deleted the requirement of Form 3040, Attendant Orientation/Supervisory Visit, and replaced it with the required elements that must be documented.

Standard 5 – Service Plan Changes

- Moved the requirements for service plan changes from Standard 3 to Standard 5.
- Deleted the requirement to **verbally** notify the case manager of any changes that may require an increase in hours or termination.
- Deleted the requirement to send appropriate forms to the DHS regional nurse for CA services on service plan changes that were initiated by the case manager.
- Added the requirement to implement service plan changes within the specified time frames.
- Deleted the requirement of Form 3040, Attendant Orientation/Supervisory Visit, and replaced it with the required elements that must be documented.

Standard 6 – Annual Reauthorization

- Moved the requirements for annual reauthorizations from Standard 3 to Standard 6.
- Revised the requirements to send appropriate forms to the DHS regional nurse on annual reauthorizations for CA services.
- Deleted the requirement of Form 3040, Attendant Orientation/Supervisory Visit, and replaced it with the required elements that must be documented.

Standard 7 – Service Interruptions

- Moved Standard 4, Service Breaks, to Standard 7, Service Interruptions.
- Combined the requirements for a priority and non-priority client.
- Deleted the requirement to obtain verbal approval from the case manager on non-priority clients.
- Added the requirement to document in the record, any service interruptions for a priority or non-priority client by the specified time frames. The documentation does not need to be sent to the case manager.
- Added the requirement for provider agency to convene an Interdisciplinary Team (IDT) when services have been suspended under 47.71(a)(7) or (b); or when an issue has been identified that prevents the agency from carrying out a requirement of the program.

Standard 8 - Complaints

- Moved Complaints from Standard 5 to Standard 8.
- Revised the requirement that complaints must be investigated and resolved as found in Chapter 49.17(b). According to Home and Community Support Services Agencies (HCSSA) licensure rules, the agency is required to document receipt of the complaint and initiate a complaint investigation within 10 calendar days of the agency's receipt of the complaint, and complete the investigation and

documentation within 30 calendar days after the agency receives the complaint, unless the agency has and documents reasonable cause for a delay.

- Added the requirements for providing complaint procedures to clients/client's representative no later than the time services begin, and no more than 12 months between each notification.
- Although provider agencies must make review of complaints accessible to DHS staff, the requirement to submit complaint findings to DHS within 30 days of receipt of the complaint was deleted.

A chart is attached that summarizes changes in the Primary Home Care Program Provider rules.

Please contact your contract manager if you have any questions regarding this information.

Sincerely,

Signature on file

Bettye M. Mitchell
Deputy Commissioner
Long Term Care

BMM:dh

Attachments – 5

1. [PHC Changes Chart](#)
2. [Form 3059](#)
3. [Form 3059 Instructions](#)
4. [Form 3858](#)
5. [Form 3858 Instructions](#)

Process	Rules effective prior to June 1, 2004	Rules in effect as of June 1, 2004
Pre-Initiation Activities	<ul style="list-style-type: none"> The provider agency evaluated the client, and developed a service plan with the client/family The provider agency obtained the Practitioner's Statement of Medical Need if Title XIX PHC or Community Attendant services. 	<p>Same</p> <p>Same</p> <p>All Pre-initiation activities must be completed before service delivery begins for retroactive cases as well as DHS referred cases.</p>
Timeframes re: completion of pre-initiation activities and initiation of service	<p>The provider agency was to complete the assessment and service plan, obtain the practitioner's statement [for PHC and CA] and request prior approval within 14 days from the referral date.</p> <p>For primary home care and community attendant services the provider agency had to initiate within seven days of the authorization date.</p> <p>For family care the provider agency had to initiate within fourteen days of the authorization date.</p>	<p>The provider agency is to complete all pre-initiation activities (client evaluation, service plan and obtaining practitioner's statement) within 14 days from the referral date, or stamped receipt date of Form 2101.</p> <p>For primary home care and community attendant services the provider agency is to initiate services on the initiation date determined by the provider agency. The service initiation date must be within seven days of the practitioner's statement date, defined as:</p> <p>The later of the following;</p> <ul style="list-style-type: none"> The practitioner's signature date, or The date the provider agency receives the practitioner's statement date <p>For family care the initiation timeframes remains the same.</p>

Authorization of Title XIX Primary Home Care	<p>The provider agency requested prior approval from the regional nurse. The provider agency sent the practitioner's statement and service plan to the regional nurse for prior approval</p>	<p>The provider agency notifies the case manager of the date of:</p> <ul style="list-style-type: none"> • Service initiation using Form 2101 • Practitioner's statement on Form 2101 <p>Case Manager enters authorization date in SAS based on practitioner's statement date, as defined in the Contracting to Provide Primary Home Care Services rules §47.3.</p> <p>Practitioners' statements will be maintained in the provider records, subject to review in contract compliance monitoring</p>
Authorization of Community Attendant Services	<p>The provider agency requested prior approval from the regional nurse. The provider agency sent the practitioner's statement and service plan to the regional nurse for prior approval</p>	<p>The provider agency notifies the case manager of the date of:</p> <ul style="list-style-type: none"> • Service initiation on Form 2101 <p>The provider agency notifies the regional nurse of the date of:</p> <ul style="list-style-type: none"> • Practitioner's statement on Form 2101 <p>Regional Nurse enters authorization date in SAS based on practitioner's statement date, as defined in the Contracting to Provide Primary Home Care Services rules §47.3.</p> <p>Practitioners' statements will be maintained in the provider records, subject to review in contract compliance monitoring</p>
<u>Annual Re-authorization of Community Attendant Services</u>	<p>The provider agency supervisor sent the following forms to the DHS regional nurse to obtain renewal of prior approval:</p> <ul style="list-style-type: none"> • Summary of client need for service 	<p>Within 14 days of Item 1 referral date on, or receipt (if stamped) of, DHS authorization form (2101), provider agency sends the DHS regional nurse:</p> <ul style="list-style-type: none"> • a copy of the Form 2101

	<ul style="list-style-type: none"> • Authorization for community care services • Attendant orientation/supervisory visit. <p>The supervisor had to submit the prior approval within 14 days of the referral date.</p>	<ul style="list-style-type: none"> • a signed statement indicating agreement or disagreement with the tasks and hours indicated on the Form 2101. • If the supervisor does not agree with tasks and hours, specific reasons must be provided. <p>The DHS regional nurse negotiates an agreement between the provider agency and the case manager if needed.</p>
Authorization of Family Care	<p>Provider agency completed the Form 2101 identifying the attendant, the service schedule and the service initiation date, and sent the form to the case manager.</p>	<p>Provider agency notifies the case manager of the date of:</p> <ul style="list-style-type: none"> • Service Initiation on Form 2101 <p>Provider agencies will not be read as out-compliance if they use another form for notification. It is considered a <u>best practice</u> to use the Form 2101 as it will include all identifying client information.</p>
Service Breaks	<p>Provider agency required to notify case manager (via 2067) within 7 days of the beginning of the service break.</p> <p>Case managers approved service breaks meeting certain criteria.</p>	<p>Service Interruptions must be documented in provider agency records</p> <ul style="list-style-type: none"> • by the 30th day of the beginning of the service interruption for priority clients, and • by the 30th day after the day the service interruption exceeds 14 days for non-priority clients. <p>Service interruption definition and documentation requirements are found in §47.63.</p>
Service Suspensions/Interdisciplinary Team (IDT) Meetings	<p>Provider agencies required to suspend services in certain circumstances.</p> <p>Provider agency could suspend service if the</p>	<p>Same</p> <p>The provider agency is to convene an IDT if</p>

	<p>client or someone in the client's home discriminated against, or sexually harassed the provider agency staff.</p> <p>If suspension due to client failure to comply with service delivery provisions, case manager might terminate services.</p> <p>Provider agency required to:</p> <ul style="list-style-type: none">• Verbally notify the DHS caseworker about the reason for suspension no later than the first DHS workday after services were suspended.• Send written notice within seven days of service suspension using Form 2067.	<p>they identify the need to discuss service delivery issues or barriers to service delivery:</p> <p>If situation is reckless behavior, discrimination, or refusal of services, the provider agency must convene an IDT meeting.</p> <p>The IDT must be convened within three working days of the date the provider agency suspends services or identifies an issue that prevents the provider agency from carrying out a requirement of the PHC program.</p> <p>The provider agency must notify the case manager by fax of any suspension due to:</p> <ul style="list-style-type: none">• Reckless behavior• Discrimination on the part of the client or others in the client's home, or• Client's refusal of service for 30 or more days. <p>by the next working day. The faxed notice of a suspension must include:</p> <ul style="list-style-type: none">(1) the date of service suspension;(2) the reason(s) for the suspension;(3) the duration of the suspension, if known; and(4) an explanation of the provider agency's attempts to resolve the problem that caused the suspension, including the reasons why the problem was not resolved. This paragraph only applies to suspensions under subsection (a)(7) and (b) of this section.
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Critical Omissions	<p>Provider agency sent packets to the DHS regional nurse for review and prior approval of Title XIX or Community Attendant Services.</p> <p>If client assessment/service plan form or the practitioner's statement was missing or if there were critical omissions or errors in required documents the provider agency did not receive prior approval.</p>	<p>The DHS regional nurse does not review for critical omissions.</p> <p>The provider agency sends:</p> <p>(for a Title XIX PHC service initiation)</p> <ul style="list-style-type: none"> • The service initiation date and practitioner's statement date to the case manager <p>(for a Community Attendant service initiation)</p> <ul style="list-style-type: none"> • The service initiation date to the case manager on copy of Form 2101 • the practitioner's statement date to the regional nurse on copy of Form 2101 <p>The provider agency must maintain documentation of the client evaluation, service plan, practitioner's statement, and all other support documentation in their records. Records are subject to review as part of contract compliance monitoring. Missing documentation or lack of required elements in documentation will result in compliance errors.</p>
Attendant Orientation	<p>Supervisors met with attendant and the client at the client home to give the attendant an orientation about the client.</p> <p>On-site orientation not required for Special Attendants, though at minimum verbal or written orientation required prior to delivery by Special Attendant.</p> <p>Special Attendants required to have six months continuous experience in delivering personal care and demonstrated competency</p>	<p>The provider must ensure each attendant is oriented. An attendant must receive orientation in person in the client's home or other service location.</p> <p>At the discretion of the supervisor an attendant may receive orientation by telephone or in the provider agency office if:</p> <ul style="list-style-type: none"> ✓ the attendant meets requirements as a Home Health Aide (per HCSSA licensure rules), <u>or</u>

	<p>in providing personal care tasks to the satisfaction of the supervisor, or meet requirements as a Home Health Aide per HCSSA licensure rules.</p>	<ul style="list-style-type: none">✓ the attendant has six months of continuous experience in delivering personal care.✓ when the service plan changes, <u>or</u>✓ the attendant previously worked for the client. <p>The provider agency supervisor may use discretion to determine if the attendant needs to be oriented if both of the following conditions apply:</p> <ul style="list-style-type: none">• The attendant previously worked for the client; and• The service plan has not changed since the attendant worked for the client.
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Service Plan Changes	<p>The provider was to notify DHS no later than the first workday after learning of a change that required an increase in hours or a service termination. Written documentation was to follow within 7 days.</p> <p>Community Attendant cases required regional nurse approval for changes between annual reauthorizations.</p> <p>An increase in hours was implemented on the beginning date shown on the authorization form.</p>	<p>The provider must notify the case manager within seven days of learning of a change that requires an increase in hours, or loss of personal care tasks (if PHC or CA) on the service plan.</p> <p>For a decrease in hours the provider agency must develop a new service plan within 21 days of learning of the need for an on-going decrease.</p> <p>Immediate increases in hours may be negotiated with and approved by the case manager.</p> <p>Rule 47.67 specifies the elements to be included in notice of service plan changes and documentation of changes.</p> <p>Those changes not classified as immediate are to be implemented on the authorization date (item 4), or <u>within</u> five days of receipt, whichever is later.</p> <p>Interim plan changes on Community Attendant cases are the responsibility of the case manager.</p>
Required Forms	<p>DHS provided forms for provider agency use. If agencies chose to use an alternate form, form approval was required.</p>	<p>Provider agencies are responsible for documenting requirements or form elements as specified in §47 rules, Contracting to Provide Primary Home Care. Forms developed by provider agencies do not require approval.</p>

PRIMARY HOME CARE PROGRAM FISCAL MONITORING GUIDE

Client Name		Medicaid No.	Date of Review (MM/DD/YY)	Review Month (MM/YY)
Review Type <input type="checkbox"/> Formal <input type="checkbox"/> Adm. <input type="checkbox"/> Other		Service Code	Service <input type="checkbox"/> Community Attendant (CA) Services <input type="checkbox"/> Primary Home Care (PHC) <input type="checkbox"/> Family Care (FC)	
Vendor No.	Agency Name		Monitor	Region

FINANCIAL ERRORS STANDARD

A. Number of Units Reimbursed (COGNOS)	A.	B. Unit Rate	C. Total Reimbursement (A X B)
	▶	X	=
D. Number of Accurate Units Provided	D.		
	▶		
E. Number of Units in Error (A minus D)	E.	F. Unit Rate	G. Total Recoupment (E X F)
	▶	X	=

EXPLANATION OF FINANCIAL ERRORS STANDARD Reference: 40TAC §47.83(b)	SERVICE DELIVERY PERIOD & UNITS IN ERROR
1. The department reimburses the provider agency for services, but the service delivery documentation is missing for the period for which services are reimbursed. The department applies the error to the total number of units reimbursed for the pay period.	
2. The department reimburses the provider agency for services, but the attendant fails to complete the units of service delivered portion of the service delivery documentation. The department applies the error to the total number of units reimbursed for the pay period.	
3. The department reimburses the provider agency for hours that exceed the total number of hours recorded on the service delivery documentation. The department applies the error to the total number of units reimbursed in excess of the units recorded on the service delivery documentation.	
4. The department reimburses the provider agency for units of service for days on which the client did not receive services. The department applies the error to the total number of units reimbursed for the day on which the client did not receive services.	
5. The department reimburses the provider agency for units of service for days on which the client was Medicaid ineligible. The department applies the error to the total number of units reimbursed for the days on which the client was Medicaid ineligible. (Not Applicable to Family Care Services).	
6. The provider agency makes a claim for services, but a valid practitioner's statement is missing. The department applies the error to the total number of units reimbursed and not covered by a valid practitioner's statement. (Not Applicable to Family Care Services).	
7. The provider agency makes a claim for services, but the practitioner's statement date is after the first day services were delivered. The department applies the error to the total number of units reimbursed before practitioner's statement date. (Not Applicable to Family Care Services).	
TOTAL NUMBER OF UNITS IN ERROR: (If Any Units in Item E.)	
TOTAL AMOUNT FOR RECOUPMENT:	(Unit(s) X Rate) \$

Comments: Enter any under billing or other information not captured above. Attach additional pages if needed.

PRIMARY HOME CARE PROGRAM
FISCAL MONITORING GUIDE

December 2004

PURPOSE

To record the client's individual financial recoupment amount identified during the review of Primary Home Care Program providers.

PROCEDURE

When to Prepare

Department staff who conduct the monitoring complete during the review.

Number of Copies

Complete one original.

Transmittal

Staff will retain the original for department records. If requested, a copy of the form is given to the provider agency, only after the monitoring results have been finalized.

Form Retention

Keep form according to the terms of the contract and according to the Primary Home Care Provider Manual.

Supply Source

This form must be printed from the forms website at

<http://www.dhs.state.tx.us/handbooks>

DETAILED INSTRUCTIONS

Client Name — Enter the name of the client whose case is reviewed.

Medicaid No. — Enter the Medicaid recipient number as it appears on Form 2101, Authorization for Community Care Services.

Date of Review — Enter the date the review is being conducted for this client file in Month/Day/Year format.

Review Month — Enter the month and year being reviewed in Month/Year format.

Review Type — Mark the appropriate box for the type of review conducted:

- Formal – Formal monitoring reviews;
- Adm. – Administrative review, if conducted; or
- Other – For follow-up reviews, or if reporting reviews for clients outside of the review sample, or if reporting outside of the review as separate findings.

Service Code — Enter the service code from COGNOS.

Service - Mark the appropriate box for the type of service being reviewed.

Vendor Number — Enter the vendor number of the provider agency being reviewed.

Agency Name – Enter the name of the provider agency being reviewed.

Monitor – Enter the name of department staff who conducted the review for this client file.

Region – Enter the number of the region to which the provider agency is assigned.

FINANCIAL ERRORS STANDARD

Complete items A. – G.

Item A — Enter the number of units the agency was reimbursed for the review month (from COGNOS).

Item B — Enter the unit rate for the authorized service code.

Item C — Enter total reimbursement amount. Multiply units reimbursed in Item A times the unit rate in Item B = total reimbursement amount in Item C ($A \times B = C$).

Item D — Enter the units provided to the client from the service delivery documentation. These units should be accurately documented as outlined in TAC rule §47.83(b) for the Primary Home Care Program. If the documentation indicates any units in error, do not include it in this section.

Item E — Enter the difference between units reimbursed and number of accurate units provided. Subtract units in Item D from units in Item A = units in error (over billed) in Item E ($A - D = E$). Notify the provider agency of any under billing and that any reimbursement can be made when proper and correct claims are submitted.

If total units entered in Item D is the same as units in Item A, enter 0.

Item F — Enter the unit rate for the service code.

Item G — Enter the total to be recouped from the provider agency. Multiply total units in error in Item E times the unit rate in Item F = total recoupment in Item G ($E \times F = G$).

EXPLANATION OF FINANCIAL ERRORS

The type of financial error will be identified in ascending order as it appears in TAC rule §47.83(b). The type of financial error (F#1-7) will be entered on Form 3687, Provider Agency Findings of Fiscal Monitoring Review Page 2, Item 4. Complete items 1. – 7. as applicable for any errors found in Item E. Enter the number of units and the service delivery period for each item in error.

Total Number of Units In Error – Enter the total number of units in error. This number comes from units in Item E. Financial errors result in 100% recoupment of the units in error.

Total Amount for Recoupment – Enter the total amount for recoupment due to financial errors. To calculate this amount, multiply the units in error for the service code, by the unit rate.

Comments: Enter any under billing or any other pertinent information not captured above.

Client Name		Medicaid No.	Date of Review: (MM/DD/YY)	Review Period: (MM/YY)
Review Type <input type="checkbox"/> Formal <input type="checkbox"/> Follow-Up	Service <input type="checkbox"/> Community Attendant (CA) <input type="checkbox"/> Primary Home Care (PHC) <input type="checkbox"/> Family Care (FC)			Status <input type="checkbox"/> Priority <input type="checkbox"/> Non-Priority
Vendor No.	Agency Name	Monitor		Region

STANDARDS CRITERIA				
STANDARD 1– Pre-Initiation Activities		YES	NO	N/A
Were the pre-initiation activities due or completed in the review period?..... If YES, continue to item a. If NO, mark Standard 1 N/A, skip to standard 2.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Did the supervisor conduct the following pre-initiating activities:				
1. Conduct an evaluation as outlined in §47.45(a)(1)?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Develop a service plan that includes the following:				
A. Is agreed upon and signed by the client and the provider agency?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. The location of service delivery?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. The tasks, total weekly hours and service schedule for services to be provided?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The frequency of supervisory visits?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. A statement that Primary Home Care Program only provides the tasks allowable in the program as outlined in §47.41?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Obtain a practitioner's statement (N/A to Family Care Services, agency transfer cases, or when transferring from PHC to CA or CA to PHC).....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: 40 TAC §47.45(a)(1-3)				
If any item in a. is marked NO, Standard 1 is NOT MET, continue to item b.				
b. Did the provider agency complete the pre-initiation activities				
• within 14 days after the referral date; or				
• within 14 days after the date the provider agency received DHS' authorization form for routine referrals; or				
• by the service initiation date negotiated with the case manager for negotiated referrals/transfers?.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: 40 TAC §47.45(c)				
If YES, mark items 1.A.-C. N/A, mark the overall standard appropriately, then continue to Standard 2.				
If NO, continue to items 1. A-C.				
1. Did the provider agency document				
• by the due date for routine referrals; or				
• orally notify the case manager before the negotiated service initiation date for negotiated referrals/transfers				
any failure to complete the pre-initiation activities including the following:				

Standard Summary: (optional)	Standard 1: _____	Standard 2: _____	Standard 3 : _____	Standard 4: _____
	Standard 5: _____	Standard 6: _____	Standard 7 : _____	

Client Name:

STANDARDS CRITERIA	YES	NO	N/A
<p>A. Reason for delay, which must be beyond the control of the provider agency?.....</p> <p>B. The date the provider agency anticipates it will complete the pre-initiation activities or specific reasons why they cannot anticipate a completion date?</p> <p>C. A description of the provider agency's ongoing efforts to complete the pre-initiation activities?.....</p> <p>REFERENCE: 40 TAC §47.45(d) If item b. is marked NO and all items in 1. A-C. are marked YES, item b. has been MET. Mark the overall standard appropriately, then continue to Standard 2. If any item in 1.A.-C. is marked NO, Standard 1 is NOT MET, continue to Standard 2.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDARD 1 IS:	MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>
STANDARD 2–Service Initiation	YES	NO	N/A
<p>Were services initiated or should they have been initiated during the review period?.....</p> <p>If YES, and this is a FC client, go to item a. If YES, and this is a non-retroactive PHC or CA client, mark item a., and f. N/A, go to item b. If YES, and this is a retroactive PHC or CA client, mark items a. - e. N/A, skip to item f. If NO, mark Standard 2 N/A, skip to Standard 3.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>a. For FC: Were services initiated</p> <ul style="list-style-type: none"> • within 14 days after the referral date; or • within 14 days after the date the provider agency received DHS' authorization form for routine referrals; or • on the date negotiated for negotiated referrals/transfers?..... <p>REFERENCE: 40 TAC §47.61(b) If YES, mark items b. and c. N/A, skip to item d. If NO, mark item b. N/A, skip to item c.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>b. For PHC or CA: Were services initiated by the initiation date determined by the provider agency, which must be</p> <ul style="list-style-type: none"> • within seven days of the practitioner's statement date; or • for negotiated referrals/transfers, on the negotiated date?..... <p>REFERENCE: 40 TAC §47.61(b) If YES, mark item c. N/A, skip to item d. If NO, continue to item c.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>c. For any delays in service initiation, the provider agency must document within the timeframes specified below:</p> <p>For FC Services:</p> <ul style="list-style-type: none"> • within 14 days after the referral date; or • within 14 days after the date the provider agency received DHS' authorization form for routine referrals; or • by the negotiated date for negotiated referrals/transfers <p>For PHC or CA:</p> <ul style="list-style-type: none"> • within seven days of the practitioner's statement date; or for negotiated referrals/transfers, on the negotiated date <p>Documentation of any failure to initiate services must include the following:</p> <p>1. Reason for delay, which must be beyond the control of the provider agency.....</p> <p>2. The date the provider agency anticipates it will initiate services or specific reasons why they cannot anticipate a service initiation date.....</p>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Client Name:

STANDARDS CRITERIA	YES	NO	N/A
<p>3. A description of the provider agency's ongoing efforts to initiate services..... REFERENCE: 40 TAC §47.61(d)</p> <p>If item a. for FC is marked NO and all items in item c. are marked YES, this item has been met, continue to item d. If item b. for PHC/CA is marked NO, and all items in item c. are marked YES, this item has been met, continue to item d. If item a. For FC or b. For PHC/CA and any item in c. is marked NO, Standard 2 is NOT MET, continue to item d.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>d. Within 14 days after initiating services, did the provider agency send the following as applicable:</p> <p>1. Written notice of service initiation date to the case manager for FC/ PHC /CA?...</p> <p>2. The practitioner's statement date to the case manager for PHC or to the regional nurse for CA (includes clients who transferred from FC to PHC/CA but N/A to agency transfers)?.....</p> <p>REFERENCE: 40 TAC §47.61(c)</p> <p>If d.1. and d.2. is marked Yes, continue to item e. If either item d.1. or d.2. is marked NO, Standard 2 is NOT MET. Continue to item e.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>e. For FC, PHC or CA: Did the supervisor orient each attendant on or before the time the attendant began to provide services?.....</p> <p>The attendant orientation documentation must be recorded on a single document that includes:</p> <ul style="list-style-type: none"> • client name and DHS client number; • attendant name; • date of attendant orientation; • whether orientation was conducted by telephone or in person with the client; • information about how the client's condition affects the performance of tasks; • tasks to be performed, • service schedule, • number of hours attendant is to provide, • total number of hours client is authorized to receive, • safety and emergency procedures, • specific situations attendant is to notify the provider agency (as outlined in §47.25 K i.-v.), • required signatures (as outlined in §47.25 L). <p>REFERENCE: 40 TAC §47.25 If YES, mark the overall standard appropriately, then continue to Standard 3. If NO, Standard 2 is NOT MET, continue to Standard 3.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client Name:

STANDARDS CRITERIA	YES	NO	N/A
f. For PHC or CA Retroactive Cases: Before requesting retroactive payment, did the provider agency do the following:			
1. Obtained the practitioner's written statement as outlined in §47.47?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The person required at least one personal care task as outlined in §47.41?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Verified and documented that the person was not receiving services from another provider agency?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Complete all pre-initiation activities as outlined in §47.45(a).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. On the day the provider agency completed the pre-initiation activities, did the provider agency contact the local DHS office by telephone to make an intake referral for eligibility process and initiate services?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did the provider agency submit the written request for retroactive payment to the case manager or, if no case manager has been assigned, to DHS intake staff within seven days after the provider agency processed the intake referral?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: 40 TAC §47.85 If any item in f.1.- f.5. is marked NO, Standard 2 is NOT MET, continue to Standard 3.			
STANDARD 2 IS:	MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>
STANDARD 3– Supervisory Visits	YES	NO	N/A
a. Were supervisory visits performed within the schedule determined by the supervisor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: 40 TAC §47.65 If YES, continue to item 1. A.-E. If NO, Standard 3 is NOT MET, continue to item 1. A.-E. Mark Items 1. A.-E. N/A if the untimely supervisory visit was not done at all.			
1. Does the documentation indicate whether the:			
A. Service plan is adequate?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Client continues to need the services?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Client needs a service plan change?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Attendant continues to be competent to provide the authorized tasks?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Attendant is delivering the authorized tasks?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: 40 TAC §47.65 If YES, continue to Standard 4. If any item in 1. A.-E. is marked NO, Standard 3 is NOT MET, continue to Standard 4.			
STANDARD 3 IS:	MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>

Client Name:

STANDARDS CRITERIA				
STANDARD 4– Attendant Orientation		YES	NO	N/A
a. Did the supervisor orient each attendant on or before the time the attendant began to provide services?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The attendant orientation must be recorded on a single document that includes:</p> <ul style="list-style-type: none"> • client name and DHS client number; • attendant name; • date of attendant orientation; • whether orientation was conducted by telephone or in person with the client; • information about how the client's condition affects the performance of tasks; • tasks to be performed; • service schedule; • number of hours attendant is to provide; • total number of hours client is authorized to receive; • safety and emergency procedures; • specific situations attendant is to notify the provider agency (as outlined in §47.25 K i.-v.); • required signatures (as outlined in §47.25 L). <p>REFERENCE: 40 TAC §47.25 If YES, continue to Standard 5. If NO, Standard 4 is NOT MET, continue to Standard 5. Mark N/A if no new attendant(s) during the review period.</p>				
STANDARD 4 IS:		MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>
STANDARD 5 – Service Plan Changes		YES	NO	N/A
<p>a. If applicable, did the provider agency notify the case manager in writing using required elements that must be documented within seven days of learning of any change that may:</p> <ul style="list-style-type: none"> • require an increase in hours; or • result in client receiving no personal care tasks (N/A to FC)..... <p>REFERENCE: 40 TAC §47.67(a) If Yes, continue to item b. If NO, Standard 5 is NOT MET, continue to item b.</p>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>b. If applicable, did the provider agency implement the service plan change</p> <ul style="list-style-type: none"> • by the authorization date; or • five days after the date the provider agency received DHS' authorization form?..... <p>REFERENCE: 40 TAC §47.67(d) If YES, continue to item c. If NO, Standard 5 is NOT MET, continue to item c.</p>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>c. If applicable, did the provider agency document by the next work day any failure to implement a service plan change on the effective date of change?...</p> <p>The documentation must include:</p> <ul style="list-style-type: none"> • The reason for delay; and • The new implementation date <p>REFERENCE: 40 TAC §47.67(e) If YES, continue to Standard 6. If NO, Standard 5 is NOT MET, continue to Standard 6.</p>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDARD 5 IS:		MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>

Client Name:

STANDARDS CRITERIA			
STANDARD 6 – Annual Reauthorization	YES	NO	N/A
<p>a. For CA: On annual reauthorizations, did the agency send a copy of DHS' authorization form and a signed statement indicating whether the supervisor agrees or disagrees with the tasks and hours indicated to the regional nurse</p> <ul style="list-style-type: none"> • within 14 days of the referral date; or • within 14 days of the date the provider agency received DHS' authorization form?.. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>REFERENCE: 40 TAC §47.73(a),(b) If YES, continue to Standard 7. If NO, Standard 6 is NOT MET, continue to Standard 7.</p>			
STANDARD 6 IS:	MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>
STANDARD 7 – Service Interruptions	YES	NO	N/A
<p>a. Did the client receive all services according to the service plan?.....</p> <p>If YES, mark item b. N/A, skip to item c. If NO, continue to items a. 1.-4. as applicable</p> <p>Valid reasons are listed in 1-4 below:</p> <p>(1) For each interruption in service did the client request that services not be provided, fewer hours be provided, or a specific attendant not provide services?.....</p> <p>REFERENCE: 40 TAC §47.63(a)(1)</p> <p>(2) For each interruption in service, was the client not at home when the attendant was scheduled to provide services?.....</p> <p>REFERENCE: 40 TAC §47.63(a)(2)</p> <p>(3) For each interruption in services is the service interruption caused by circumstances described in §47.71(a)-(b), Suspensions?.....</p> <p>REFERENCE: 40 TAC §47.63(a)(3)</p> <p>(4) For each interruption in service, was it beyond the control of the provider agency, such as acts of nature and other disasters?.....</p> <p>REFERENCE: 40 TAC §47.63(a)(4)</p> <p>If any item in 1.-4. is marked NO, Standard 7 is NOT MET. Continue to item b.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>b. Did the provider agency document all service interruptions by the 30th day after :</p> <ul style="list-style-type: none"> • the beginning of the service interruption for a priority client; or • the day service interruption exceeds 14 consecutive days for a non-priority client..... <p>REFERENCE 40 TAC §47.63(c)(1),(2) If YES, continue to item c. If NO, Standard 7 is NOT MET, continue to item c.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STANDARDS CRITERIA	YES	NO	N/A
<p>c. Did the provider agency convene an IDT (conducted by telephone conference call or in person) within three working days of the date the provider agency:</p> <ul style="list-style-type: none"> suspended services to a client under §47.71(a)(7) or (b); or identified an issue that prevented the provider agency from carrying out a requirement of Primary Home Care Program?..... <p>REFERENCE: 40 TAC §47.49(b)(1) If Yes, continue to item 1. If NO, Standard 7 is NOT MET, continue to item 1.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>1. Did the provider agency implement the recommendations of the IDT or discharge the client and refer the case back to the case manager for referral to another provider agency within two working days after the IDT meeting?.....</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>REFERENCE: 40 TAC §47.49(d) If YES, continue to item 2. If NO, Standard 7 is NOT MET, continue to item 2.</p>			
<p>2. Did the provider agency include the following in the documentation when they convened the IDT:</p> <p>A. Specific reasons for calling the IDT meeting?.....</p> <p>B. Participants in the IDT meeting?.....</p> <p>C. Recommendations of the IDT meeting?.....</p> <p>D. Agency's action as a result of the IDT recommendations?.....</p> <p>E. Reasons for the provider agency's actions?.....</p> <p>REFERENCE: 40 TAC §47.49(e) If YES, continue to Standard 8. If NO, Standard 7 is NOT MET, continue to Standard 8.</p>	<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/>
<p>STANDARD 7 IS:</p>	<p>MET</p> <input type="checkbox"/>	<p>NOT MET</p> <input type="checkbox"/>	<p>N/A</p> <input type="checkbox"/>

STANDARD 8—Complaints				YES	NO	N/A
a. Does the provider agency maintain a log of the complaints and make review of complaints accessible to DHS staff?..... REFERENCE: §49.17(d)(3) If YES, continue to item b. If NO, Standard 8 is NOT MET, continue to item b.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were there any complaints during the review period?..... If YES, complete the table below then continue to item c. If NO, mark item c. 1. and 2. N/A.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List any clients with any complaints received by the client/client's representative or any other party on behalf of the client received during the review period. Do not list the complainant name, only the client's name. Attach additional pages as needed.						
Client Name:	Date Complaint Received:	Date Investigation & Resolution Completed:	Date Services Began (for initial Cases):	Date of Most Recent Notification of Procedures:	Date of Previous Notification of Procedures:	Completed * Timely (Y/N):
NOTE: *Completed means: • investigated and resolved in accordance with HCSSA licensure rules; • obtaining the client/client's representative initials on client-initiated complaints or a witness's signature when the client refuses to sign; and • providing complaint procedures to clients/client's representatives in writing no later than the time services begin (for initial cases) and no more than 12 months between each notification (for ongoing cases).						
c. Is there documentation that the provider agency:						
1. Investigated and resolved all complaints in accordance with applicable HCSSA licensure rules?.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provided complaint procedures to each client/client's representative in writing no later than the time services began (for initial cases) and no more than 12 months between each notification (for ongoing cases)?.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFERENCE: §49.17(a-f), §49.18(a),(d) If either item c.1. or c.2. is marked NO, Standard 8 is NOT MET						
STANDARD 8 IS:				MET <input type="checkbox"/>	NOT MET <input type="checkbox"/>	N/A <input type="checkbox"/>

PRIMARY HOME CARE PROGRAM
CONTRACT COMPLIANCE MONITORING GUIDE

December 2004

PURPOSE

To serve as the primary document to record findings of contract compliance monitoring of Primary Home Care (PHC), Family Care (FC), and Community Attendant (CA) services providers.

PROCEDURE

When to Prepare

Department staff who conduct the monitoring complete Form 3858 when reviewing a case.

Number of Copies

Complete one original.

Transmittal

Staff will retain the original for department records. If requested, a copy of the form is given to the provider agency only after the monitoring results have been finalized.

Form Retention

Keep form according to the terms of the contract and according to the *Primary Home Care Provider Manual*.

Supply Source

This form must be printed from the forms website at <http://www.dhs.state.tx.us/handbooks>

DETAILED INSTRUCTIONS

Client Name — Enter the client's name as it appears on Form 2101, Authorization for Community Care Services.

Medicaid No. — Enter the Medicaid recipient number as it appears on Form 2101.

Date of Review — Enter the date the review is being conducted for this client file in Month/Day/Year format.

Review Period — Enter the month(s) and year(s) being reviewed in month/year format.

Review Type — Mark the appropriate box for the type of review being conducted: Formal or Follow-Up.

Service — Mark the appropriate box for the type of service being reviewed.

Status — Mark the appropriate box for the priority level from item 10, Form 2101:

Priority — If, during the review period, the client was assigned a priority status; or

Non-Priority — If, during the review period, the client was assigned a non-priority status.

Vendor No. — Enter the vendor number of the provider agency being reviewed.

Agency Name — Enter the name of the provider agency being reviewed.

Monitor — Enter the name of department staff who conducted the review for this client file.

Region — Enter the number of the region to which the provider agency is assigned.

Services in the Primary Home Care Program must be delivered under the Personal Assistance Services (PAS) category of license.

Standard Summary: (Optional) — At the bottom of page 1, staff may enter the overall compliance for Standards 1 – 7 as: **M**=MET, **NM** = NOT MET, or **N/A** = Not Applicable (N/A).

Contract staff must make copies of any deficient standards and maintain with their monitoring records.

Standard 1, Pre – Initiation Activities — Apply Standard 1 to cases in which pre-initiation activities were due or completed during the review period. Review all cases in which the 14th day from the referral date (Item 1, Form 2101, Authorization for Community Care Services), the agency receipt date, or the negotiated date falls in the review period, regardless of when the pre-initiation activities were completed. For routine referrals, review only one month before the review period, to determine whether the pre-initiation activities were done within 14 calendar days of the referral date (Item 1 on Form 2101), or agency receipt date.

This standard also applies to any transfer cases in the review sample where applicable. A transfer can be a client transferring from one provider agency to another, or from one program to another. Transfers are negotiated with case workers and will be reviewed as negotiated when applicable. Not all items will be applicable to transfers. For example: The

receiving agency would not need to obtain a practitioner's statement for a PHC client transferring from one provider agency to another, however, a practitioner statement would be needed if the client was transferring from Family Care to Primary Home Care for the first time.

Standard 1 – Monitoring Protocol

- Item a. 1. & 2. – The provider agency may combine the evaluation and service plan into a single document, but each item must be clearly identified.
- Item a. 1. – The provider agency must conduct an evaluation as outlined in TAC §47.45(a)(1). The evaluation must be a single document that includes the person's self-report of the date(s) and reason(s) for any hospitalization within the last three months; and the assistance needed for the person to achieve activities of daily living. If during the evaluation the agency determines that the client exhibits reckless behavior that results in imminent danger to the health and safety of the client, the agency must convene an IDT meeting as outlined in §47.49 to discuss barriers to service delivery.
- Item a. 2. A. – Determine the date the service plan was signed. Determine the date services were initiated. The service plan must be signed on or before services began.
- Item a. 2. B. – Determine the location of service delivery.
- Item a. 2. C. – Determine if the service schedule is variable or fixed.
- Item a. 3. – For PHC or CA services, the provider agency must obtain a practitioner's statement which is a document that includes a statement signed by a practitioner that the client has a current medical need for assistance with personal care tasks and other activities of daily living; and certification that the provider agency verified with the United States' Centers for Medicare and Medicaid Services that the practitioner is not excluded from participation in Medicare or Medicaid. Review for documentation of written or oral practitioner's statement date.
- Item b. – Determine the date all pre-initiation activities were completed to see if done by the specified time frames. Determine the referral date found on Item 1 of form 2101, or the date the provider agency received Form 2101, whichever of the two dates is later. If the agency failed to stamp the receipt date on the form, use the referral date to determine timeliness. For negotiated referrals, determine the negotiated date. If these time frames are met, mark items 1. A. – C. N/A. If the time frames are not met, continue to items 1. A. – C.
- Item b. 1. – Determine the documentation date for failure to complete the pre-initiation activities. This must be documented within 14 days of the referral date, or within 14 days after the provider agency received Form 2101, (whichever of the two dates is later), or for negotiated referrals, the provider has until prior to close of business on the day services were negotiated to begin, or the next workday if the negotiated start date falls on a weekend.
- Item b. 1. A. – C. – Determine the date of documentation. Determine the reason for the delay, which must be beyond the control of the provider agency. Determine from documentation either the date the provider agency anticipates they will complete the pre-initiation activities or the specific reason why the provider agency cannot anticipate a completion date, and a description of the agency's ongoing efforts to complete the pre-initiation activities.

For each item a. through b.:

- mark Yes, No, N/A, or skip an item as instructed on the form; and
- review all items a. – b. as instructed on the form, even if one item causes the overall standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 1- Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 2, Service Initiation — Apply Standard 2 to cases in which services should have been initiated or were initiated during the review period. Review all cases in which the service initiation due date (7th or 14th day, as applicable) falls in the review period, regardless of when services were initiated. Review only one month before the review period to determine whether services were initiated timely or the reason for delay was documented.

This standard also applies to any transfer cases in the review sample where applicable. A transfer can be a client transferring from one provider agency to another, or from one program to another. Transfers are negotiated with case workers and will be reviewed as negotiated when applicable. Not all items will be applicable to transfers. For example: The receiving agency would not need to obtain a practitioner's statement for a PHC client transferring from one provider agency to another, however, a practitioner statement would be needed if the client was transferring from Family Care to Primary Home Care for the first time.

Standard 2 – Monitoring Protocol

- Item a. – For FC services, determine the referral date found on item 1 of Form 2101, or the date the provider agency received Form 2101, whichever of the two dates is later. If the agency failed to stamp the receipt date on the form, use the referral date to determine timeliness. For negotiated referrals, determine the negotiated date. Determine the service initiation date by reviewing the service delivery documentation.
- Item b. – For PHC or CA services, determine the practitioner's statement date. The practitioner's statement date is the later of the following: 1). The practitioner's signature date on the practitioner's statement; or the date the provider agency receives the practitioner's statement. If the provider agency fails to stamp the receipt date on the form, the date of the practitioner's signature will be used to determine the practitioner's statement date; or the date of the practitioner's oral statement obtained for a negotiated referral. The provider agency must document the practitioner's oral statement date on the practitioner's written statement required in §47.47(c)(2). For negotiated referrals, determine the negotiated date. Determine the service initiation date by reviewing the service delivery documentation.
- Item c. 1. – 3. – Determine if the provider agency documented any failure to initiate services by the specified time frames. **For FC:** determine the referral date found on item 1 of Form 2101, or the date the provider agency received Form 2101, whichever of the two dates is later. If the agency failed to stamp the receipt date on the form, use the referral date to determine timeliness. For negotiated referrals, determine the negotiated date. **For PHC or CA:** Delays must be documented within seven days of the

practitioner's statement date, or for negotiated referrals, on the negotiated date.

Determine the practitioner's statement date. From the documentation, determine the reason for the delay, which must be beyond the control of the provider agency, and not caused directly by the provider agency. Determine either the date the provider agency anticipates they will initiate services or specific reasons why the provider agency cannot anticipate a service initiation date, and a description of the agency's ongoing efforts to initiate services.

- Item d. – Determine the date services were initiated. Determine the date written notice of service initiation was sent to the case manager. Determine the date the practitioner's statement date was sent to the case manager or regional nurse as applicable. Use the signature date of the written notice (which can be Form 2101, 2067, or whatever agency used as written notice) to measure compliance.
- Item e. – The method of orientation must be conducted as outlined in §47.25(b). Determine the date the attendant(s) were oriented and date they began providing services to the client.
- Item f. – Not Applicable to Family Care Services. Determine the date the provider agency made a referral to DHS. Determine the date services were initiated by reviewing the service delivery documentation. Services must not begin before the agency completes the pre-initiation activities and processes intake referral.
- Item f. 1. – Determine the practitioner's statement date.
- Item f. 2. – Determine the service plan date.
- Item f. 3. – Determine the date the agency verified and documented that the person was not receiving services from another provider agency.
- Item f. 4. – Determine the date all pre-initiation activities were completed.
- Item f. 5. – The written request must include the following: a copy of the service plan, a copy of DHS' Practitioner's Statement of Medical Need form, name of the provider agency, the contact information for the person being referred, the date services were initiated, the tasks to be provided to the person, and the weekly hours and cost per hour that was charged to the person, if applicable.

For each item a. through f.:

- mark Yes, No, N/A, or skip an item as instructed on the form; and
- review all items a. – f. as instructed on the form, even if one item causes the overall standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 2 –Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 3, Supervisory Visits — Apply Standard 3 to all cases in the review sample. Review before the review period, if needed, to determine whether the required timeframes were met.

Item a. — The supervisory visit must be done on or before the last day of the month the visit is due. The assigned supervisor sets the visit frequency for PHC/FC/CA clients.

Use the following to determine if item a is applicable:

"Was a visit completed during the review period?" If the answer is "yes," then always review item a. The contract manager must follow these steps to determine if item a is MET or NOT MET:

- Determine the date of the previous supervisory visit (look as far back as necessary to find the previous supervisory visit).
- Determine the visit frequency indicated on the previous supervisory visit.
- Determine the due date for the next supervisory visit (based on the previous supervisory visit and the visit frequency).
- Determine if the supervisory visit completed during review period was completed **on or before** the due date for the next visit.

If the supervisory visit was completed on or before the due date for the next supervisory visit, mark Item a. Yes. If the supervisory visit was not completed on or before the due date for the next supervisory visit, mark Item a. No.

"Was a visit completed during the review period?" If the answer is "no," then review Item a only if applicable. The contract manager must follow these steps to determine if item a. is N/A or NOT MET.

- Determine the date of the previous supervisory visit (look as far back as necessary to find the previous supervisory visit).
- Determine the visit frequency indicated on the previous supervisory visit.
- Determine the due date for the next supervisory visit (based on the previous supervisory visit and the visit frequency).
- Determine if the due date for the next supervisory visit is **on or before** the last day of the review period.

If the due date for the next supervisory visit is on or before the last day of the review period, mark item a. NO (regardless of how far the due date is before the review period). If the due date for the next supervisory visit is after the last day of the review period mark item a. N/A. The provider agency still has time after the review period to complete the supervisory visit before the due date.

Standard 3 – Monitoring Protocol

- The supervisor establishes the frequency of supervisory visits to be conducted at least annually.
- Review item a. for supervisory visits that were completed during the review period; for supervisory visits with a due date during the review period; and for supervisory visits with a due date before the review period that were not completed by the end of the review period (example: Review period is March, April and May. The supervisory visit was due in February and was still not completed by May). The supervisory visit can be done on or before the last day of the month that it is due.

- Item a. - Determine the date of the previous supervisory visit. Determine the frequency that was set at the previous supervisory visit. Determine when the next supervisory visit is due. Determine the date the supervisory visit was conducted.
- Items 1. A. – E. is reviewed even if the supervisory visit is done untimely to determine if all elements are documented as required. If the untimely visit was not done at all, mark items 1. A. – E. N/A.

For each item in a.:

- mark Yes, No, or N/A as appropriate; and
- review all items in a. as instructed on the form, even if one item causes the overall standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 3 –Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 4, Attendant Orientation – Apply Standard 4 to all cases in the review sample.

Item a. —An attendant must receive orientation in person in the client’s home or other location where services are delivered. The client must be present when the attendant receives orientation in person. An attendant may receive orientation by telephone or in the provider agency office at the discretion of the supervisor as outlined in §47.25. Orientation is not required for supervisors who are acting as attendants.

Standard 4 – Monitoring Protocol

- Read for any attendants that were new to the client during the review period. The method of orientation must be conducted as outlined in §47.25(b).
- Item a. – Determine the date the attendant(s) were oriented and date they began providing services to the client.

For item a:

- mark Yes, No, or N/A as appropriate

STANDARD 4- Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 5, Service Plan Changes – Apply Standard 5 to all cases in the review sample where a service plan change occurred. If there were not any service plan changes in the review period, mark all items in this standard, N/A.

Standard 5 – Monitoring Protocol

- Item a. – The notification to the case manager must include the date the provider agency learned of the need for the change, the reason for the change, the type of change that includes the number of hours, a signature and date of the provider agency representative.
- Item b. – Determine the authorization date from item 4. of Form 2101 or within five days after the date the provider agency received Form 2101, whichever of the two dates is

later. If the agency failed to stamp the receipt date on the form, use the authorization date.

- Item c. – Determine the implementation date by reviewing service delivery documentation. If the agency was not able to implement the service plan change, the documentation must include the reason for failure to timely implement the service plan change and the new implementation date.

For each item a. through c.:

- mark Yes, No, N/A, or skip an item as instructed on the form; and
- review all items a. – c. as instructed on the form, even if one item causes the overall standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 5- Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 6, Annual Reauthorization - This standard only applies to Community Attendant (CA) Services. Apply Standard 6 to all CA cases in the review sample for any cases that an annual reauthorization occurred.

Standard 6 – Monitoring Protocol

- Determine the referral date found on item 1 of Form 2101, or the date the provider agency received Form 2101, whichever of the two dates is later. If the agency failed to stamp the receipt date on the form, use the referral date to determine timeliness.

For item a:

- mark Yes, No, or N/A as appropriate

STANDARD 6- Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 7, Service Interruptions — Apply Standard 7 to all cases in the review sample for the entire review period. Review the month before the review period, if needed, to determine whether a service interruption occurred during the review period.

Item a.— Review item a for all priority and non-priority clients. If item a is marked NO, and any instance of a service interruption during the entire review period does not have a reason documented or the reason documented is not valid, Standard 4 is NOT MET.

Standard 7 – Monitoring Protocol

- Item a. – Review the service delivery documentation to determine if there is a service interruption. If the client did not receive all services according to the service plan, and any instance of a service interruption during the entire review period does not have a reason documented or the reason documented is not valid, Standard 4 is marked as NOT MET.
- For a **Fixed Schedule**: A service interruption begins on the first day services are scheduled but not delivered.

- For a **Variable Service Schedule**: The service interruption begins the Sunday following the week the client did not receive all the weekly hours on a service plan approved by the client. This applies to priority and non-priority clients.
- **Priority clients** – A service interruption occurs any time the client does not receive all services according to the service plan. Any instance of a service interruption must have the reason for the interruption documented.
- **Non-priority clients** – A service interruption occurs any time the client does not receive services for a period that exceeds 14 consecutive days. Each instance of service interruption that exceeds 14 consecutive days must have the reason for the interruption documented.
- Item b. – For any service interruptions, determine the date the interruption began. Determine the date documentation of service interruption is due. Determine the date of the documentation for any service interruptions.
- Item c. – If applicable, a provider agency must request an IDT meeting under §47.71(a)(7) the client or someone in the client’s home exhibits reckless behavior, which may result in imminent danger to the health and safety of the client, the attendant, or another person. Or under 47.71(b). See TAC rules for detailed list of Optional Suspensions. Determine the date services were suspended, or the date issues were identified by the provider agency. Determine the date the IDT meeting was convened.
- Item c. 1. – Determine the implementation date or the date the case was referred back to the case manager.

For each item a. through c.:

- mark Yes, No, N/A, or skip an item as instructed on the form; and
- review all items a. – c. as instructed on the form, even if one item causes the overall standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 7 – Mark the overall standard as MET, NOT MET, or N/A, as appropriate.

Standard 8, Complaints — Complete Standard 8 only once for each provider agency. Do not figure into the overall percentage.

Item a — Mark this as NOT MET, if there is no complaint log.

Item b. – If this item is marked NO, do not review item c., mark it item c. 1. and c. 2. N/A.

Item c. – Mark Standard 8 NOT MET if item c.1. or c.2. is marked NO for any complaints received from a sample or non-sample client during the review period.

Standard 8 – Monitoring Protocol

- The provider agency is no longer required to submit complaint findings to DHS within 30 days of receipt of the complaint, however, must make review of complaints accessible to DHS staff.

- Item c. 1. and 2. – Mark either c. 1. or c. 2. No, for any complaint that is listed on the complaint log from a sample or a non-sample client during the review period that is not completed timely.
- Item c. 1. – The provider agency must investigate and resolve complaints as required by HCSSA licensure rules. The provider agency is required to document receipt of the complaint, initiate an investigation within 10 calendar days of receipt of the complaint and complete the investigation within 30 calendar days after the agency received the complaint unless the agency documented reasonable cause for delay.
- Item c. 2. – The provider agency's complaint procedures must be provided to the client or client's representative no later than the time services begin, and no more than 12 months between each notification. The complaint procedures can be provided on or before the last day of the month the notification is due. Example: If the notification was provided to a client on October 15, 2003, they must be provided to the client no later than October 31, 2004.
- Do not include the findings for Standard 8 in determining the compliance level for the provider agency. Report Standard 8 findings separately in the findings section of Form 3853, Provider Agency Evaluation Summary.
- Request that the provider agency develop a corrective action plan if compliance with Standard 8 is not met.

STANDARD 8 – mark overall standard as MET or NOT MET, as appropriate.